DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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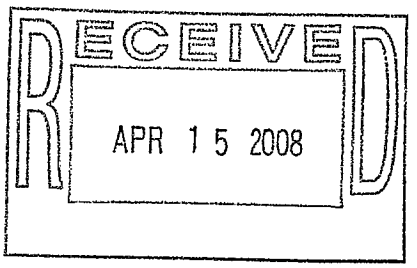

Mr. Stan Rosenstein
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capital Avenue, MS 0000
P. O. Box 997413
Sacramento, CA 99859-7413

Dear Mr. Rosenstein:

Enclosed is our final report (Control Number 09-FS-2007-CA-04) entitled "Review of California Medi-Cal Hospital/Uninsured 1115 Demonstration Waiver".

The purpose of our review was to assess the California Department of Health Care Services' calculation of the inpatient hospital interim per diem rate to determine if the calculation was in compliance with the certified public expenditures (CPE) Protocol approved in the Special Terms and Conditions of the Demonstration Waiver and the California State Plan. We also reviewed how the 22 governmental hospitals determined the "uninsured" patient days and charges to support the expenditures claimed under the Safety Net Care Pool and Disproportionate Share Hospital fund.

We found that the State's calculation of the interim rate calculation and the supporting documentation comply with the CPE Protocol, as approved by the Waiver and California State Plan. The Workbooks used to calculate the interim rate, comply with the instructions on page 3 of the CPE Protocol. We also found that the "uninsured" patients and charges claimed in the Workbooks comply with the definition of "uninsured" patients used in the CPE protocols. The hospitals' documentation supported the number of "uninsured" patient days and charges reported in the Workbook.

Should you or your staff require further details regarding this matter, please contact Mary Ann Guiney at (916) 414-2375 or e-mail her at: Maryann.Guiney@cms.hhs.gov.

Sincerely,

Jackie L. Glaze

Jackie L. Glaze
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

FINAL

Financial Management Report

REPORT ON FINANCIAL MANAGEMENT REVIEW

OF CALIFORNIA MEDI-CAL HOSPITAL/UNINSURED 1115

DEMONSTRATION WAIVER

09-FS-2007-CA-04

MARCH 17, 2008

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH CARE SERVICES

FOR THE PERIOD OF STATE FISCAL YEAR 2005-06

DIVISION OF MEDICAID AND CHILDREN'S HEALTH

OPERATIONS

CENTERS FOR MEDICARE & MEDICAID SERVICES

SAN FRANCISCO REGIONAL OFFICE

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I. EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) San Francisco Regional Office (RO) reviewed the State of California's calculation of the inpatient hospital interim per diem rate to determine if this calculation is in compliance with the certified public expenditure (CPE) Protocol approved in the Special Terms and Conditions (STCs) of the California Medi-Cal Hospital/Uninsured 1115 Demonstration Waiver ("Waiver") and California State Plan. This interim payment is calculated for the purpose of Medicaid inpatient hospital reimbursement to 22 designated hospitals[1] under the state plan, inpatient hospital reimbursement for the uninsured under the Waiver Safety Net Care Pool (SNCP), and Disproportionate Share Hospital (DSH) reimbursement. We also reviewed how the 22 governmental hospitals determined the "uninsured" patient days and charges to support those expenditures claimed under SNCP and DSH.

We found that the State's calculation of the interim rate complied with the CPE Protocol, as required by the Waiver and state plan. We also found that the hospitals were appropriately determining and documenting individuals as "uninsured".

II. INTRODUCTION/BACKGROUND

On August 31, 2005, CMS approved a new Medicaid Section 1115 Demonstration Waiver for California, entitled the "Medi-Cal Hospital/Uninsured Care Demonstration Waiver" (Waiver 11-W-00193/9). This Waiver, in conjunction with the California Medicaid State Plan , (Section Attachment 4.19A, page 46, "Reimbursement to Specified Government-Operated Hospitals for Inpatient Hospital Services," and page 18, "Increase in Medicaid Payment Amounts for California Disproportionate Share Hospitals"), governs the reimbursement for Medicaid fee-for-service (FFS) inpatient hospital services and expenditures under the DSH Program. The Waiver also created a "Safety Net Care Pool" to provide funding for the costs of providing care for uninsured individuals.

In California, the Department of Health Care Services (DHCS) is responsible for administering the State's Medicaid Program (called "Medi-Cal" in California). As agreed to in the Waiver, the 22 designated governmental hospitals are reimbursed for Medicaid FFS inpatient hospital services, DSH, and SNCP expenditures on the basis of CPEs. During each fiscal year, DHCS makes interim payments to the 22 governmental hospitals based on those hospitals' CPEs for

[1] The 22 designated hospitals are sometimes referred to as 23 designated hospitals. UCLA and UCLA-Santa Monica are counted as one facility in the Waiver. The 22 designated hospitals include: State Government Operated University of California Hospitals – UC Davis Medical Center, UC Irvine Medical Center, UC San Diego Medical Center, UC San Francisco Medical Center, and UC Los Angeles Medical Center. Seventeen Non-State Government Operated – Los Angeles County owned, Harbor/UCLA Medical Center, Harbor/Martin Luther King Medical Center, Olive View Medical Center, Rancho Los Amigos National Rehabilitation Center, and University of Southern California Medical Center. The other Governmentally-Operated Hospitals include: Alameda County Medical Center, Arrowhead Regional Medical Center, Contra Costa Regional Medical Center, Kern Medical Center, Natividad Medical Center, Riverside County Regional Medical Center, San Francisco General Hospital, San Joaquin General Hospital, San Mateo County General Hospital, Santa Clara Valley Medical Center, Tuolumne General Hospital, and Ventura County Medical Center.

Medi-Cal FFS, DSH, and the SNCP, in accordance with a CPE protocol approved by CMS that has been incorporated into the STCs of the Waiver[2] and the state plan. These interim payments are later reconciled through a two step process to actual costs.

III. PURPOSE AND SCOPE

The purpose of the review was to: (1) determine if the interim rate calculation is in compliance with the STCs of the Waiver and CPE protocol; and, (2) determine how the hospitals reported "uninsured" patient days and charges for claiming under DSH and the Waiver SNCP. Specifically, the review was to determine whether:

> (1) The Workbook [3] ("workbook") calculation of the interim rate could be supported by the information from the Medi-Cal "as filed" cost report and was adjusted in accordance with the CPE protocol.
>
> (2) The statistical information submitted in the Workbooks by the 22 designated hospitals, accurately claimed "uninsured" patient days and charges as defined under the Waiver.

Our review was conducted March 17 through April 26, 2007, at the State's offices in Sacramento, California, and onsite at three of the 22 governmental hospitals. We performed our onsite review at Ventura County Medical Center and Olive View Medical Center (in Los Angeles) both county-owned hospitals, and the UC Davis Medical Center, a University of California-owned hospital.

Calculation of the Interim Rate

To review the calculation of the interim rate, we discussed the procedures used by DHCS to calculate the interim rate with DHCS staff and reviewed DHCS' hospital files,[4] including the completed Workbook and related source documents, submitted by each hospital to calculate the interim payment. Specifically, we

- Traced the information in the Workbook to the "as filed" 2005 Medi-Cal Cost Report, Worksheets A, B, C, D. and E;
- Reviewed Schedule 3 of the Workbook and identified the hospitals that claimed the approved CPI and additional expenses;

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[2] On October 5, 2007, the Waiver was amended to incorporate the approved CPE protocol and the STCs were renumbered. However, all references to STCs in this report refer to the Waiver as originally approved.
[3] The CPE Protocols are also referred to as Paragraph 14 of the Special Terms and Conditions. The designated hospitals refer to the CPE protocols as Paragraph 14 or the "Workbook."
[4] The State's individual hospital files contain: all written and electronic correspondence between the hospital and the State; the completed Workbook submitted by the hospital; the "as filed" 2005 Medi-Cal Cost Report; the last finalized Medi-Cal Cost Report audited by the Audit & Investigation (A & I) the A & I audit adjustment report for that year; and any other documentation submitted by the hospital to support the claimed patient days and charges

- Verified that the State's calculation of the rate was adjusted to the MMIS reported Medicaid days and charges;
- Verified that the State's calculation of the rate was supported by the hospital documentation of "uninsured" day and charges;
- Verified that the State's calculation was adjusted for the 2001 A & I audit adjustments;
- Verified that the State's calculation was adjusted for Interns and Residents' costs; and
- Verified that the State made additional reductions of the interim rate to avoid overpayments.

Hospital Reporting of "Uninsured" Patient Days and Charges

The CPE protocol defines "uninsured" patients as:

> "...individuals with no source of third party insurance coverage for the inpatient and outpatient hospital services they receive that would have been benefits eligible for federal reimbursement under Title XIX had these individuals been eligible Medi-Cal beneficiaries, and those costs identified in Attachment D of the Special Terms and Conditions." [5]

To determine how the hospitals reported "uninsured" patient days and charges for claiming under DSH and the Waiver SNCP, we went onsite to each hospital. We met with the hospitals' financial staff, discussed the admitting policies and procedures, discussed how each hospital identified an individual as "uninsured" and reviewed the supporting documentation for the days and charges claimed in the Workbook for our review period.

Specifically, we obtained a list of the "uninsured" patients from 2005-06 and randomly selected 30 patient account numbers from this list. We reviewed the individual patient's financial records and verified that the hospital:

- Followed its written policies and procedures;
- Attempted to obtain other third party insurance coverage;
- Checked for existing coverage under Medi-Cal;
- Documented all attempts to collect payment from the patient; and
- Attempted to obtain county or city indigent funds under California law.

[5] CPE Protocol, Section Safety Net Care Pool, Page 7, Paragraph 7.

We then traced the number of patient days and charges from the patient's bill to the days and charges claimed on the "uninsured" list and verified that the dates of service were between July 1, 2005 and June 30, 2006.

IV. FINDINGS

We found that the State's interim rate calculation and the supporting documentation comply with the CPE Protocol, as approved in the Waiver and California State Plan. The Workbooks used to calculate the interim rate, comply with the instructions on page 3 of the CPE Protocol. We also found that the "uninsured" patient days and charges claimed in the Workbooks comply with the definition of "uninsured" patients used in the CPE protocols. The hospitals' documentation supported the number of "uninsured" patient days and charges reported in the Workbook.

V. ADDITIONAL OBSERVATIONS

Below are additional observations about the State's implementation of the CPE methodology based on our review:

1. For the State's calculation of the interim rate, the Los Angeles County hospitals do not submit the "as filed" Medi-Cal Cost Reports, but submit an amended Medi-Cal cost report to further exclude any non-reimbursable expenses, non hospital based clinics, PPP clinics and CBRC clinics. [6] Under the language of the Waiver these expenses should have been removed already as part of the as filed cost report. The amended report does not technically meet the criteria set forth in Paragraph 14, CPE Protocols. Page 2, Section under Notes (ii) which defines the "filed Medi-Cal 2552-96 cost report" as the cost report that is submitted by the hospital to A & I and is due five months after the end of the cost reporting period. We agree, however, with the amendments in excluding non-reimbursable hospital expenses.

2. The State hospital files do not include the "as filed" Medicare Cost Report. There is no language in the STCs that requires the State to compare the information in the Medi-Cal Cost Report to the Medicare Cost Report. But the CPE Protocol does state, on page 1, that adjustments and reclassifications are made to the Medi-Cal 2552-96 "in accordance with Medicare reimbursement principles." Furthermore, the CPE Protocol states that the "alternative statistics used by Los Angeles County Hospitals must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation." [7] Given that the Medicare Cost Reports are not available from the State hospital files, we could not determine if the State ensures that there is consistency between the Medi-Cal Cost Report and the Medicare Cost Report with the application of Medicare reimbursement principles, and, that for Los Angeles County Hospitals specifically, alternative statistics used in the Medi-Cal Cost Report and Workbook are consistent with those used in the Medicare Cost Report.

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[6] Los Angeles County expects to receive reimbursement for the clinic expenses with the approval of SPA 05-0022 (Designated hospital clinic SPA), 05-009 (L. A. County clinic SPA for cost based reimbursement) , and 06-016 (Statewide Supplemental Payment SPA)

[7] Paragraph 14 of the STCs, page 2 Section Notes iii.

3. To calculate the initial interim per diem rates, the State reviewed the audit adjustments from the last finalized Medi-Cal Cost Report. [8] The State applied any adjustments to the Workbook data to correct the hospital's calculation. . The State also withheld between 5% to 39% from the interim rate to limit overpayments to the hospitals. The State notified the hospitals of changes to their submitted rate calculations. Again in early 2007, after a cursory review of the 2006 "as filed" Medi-Cal cost reports,[9] the State reconciled the statistical and charge information to the Workbook calculations and made additional adjustments to the interim per diem rate. During the period of our review, the State had informed the hospitals of changes to their rates that were based on the 2006 cost report. A financial review of the second stage of the CPE Protocol will focus on the "interim reconciliation" of the rates to the "as filed" cost report. This review is scheduled to be completed by the last quarter of FFY 2008.

4. In our review of the individual Workbooks for the 22 designated hospitals, we found that the base year computed costs of seven hospitals were adjusted for the 2006 period by a CPI inflation factor of 5.2% and additional equity trending factors as shown in the table below. The CPE protocol states that the base year costs "can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS" and "may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations and circumstances...such costs must be properly documented by the hospital and subject to review by the State and CMS." CMS did provide prior approval of the State's use of the CPI in lieu of the hospital market basket update factor. However, the State did not submit the additional equity adjustments above the CPI for these seven hospitals for CMS' prior approval. Nonetheless, as part of this FMR, we did find that the additional adjustments were consistent with Medicare cost principles and supported by adequate documentation.

EQUITY TRENDING FACTOR

Hospital Name	Additional Trending Expenses	Nurse Cost Ratio	Nurse Shortage Cost	Hospital Operations	Retirement Plan Increases	E/RE/R Call	A-87 Compliance	Dietary Cost Increase	Other Skilled Staff	Total Rate Increase
Kern County	$202		$92		$110					$202
L A Co. Olive View	$32	$32								$32
L A Co. Harbor-MLK	$241		$241							$241
Santa Clara Valley	$11	$11								$11
Tuolumne General	$217	$39.26	$46.23	$56.6		$1.25	$46.45	$24.16	$3.49	$217
UC CA San Diego	$56	$31.13	$24.67							$56
Ventura County	$124			$124						$124

[8] The last audited Medi-Cal Cost Reports were for FYE 2001.

[9] Exception – all Los Angeles County owned hospitals filed "amended" cost reports. See Observation No. 1 and footnote 6.